Pain management regimes and opiate toxicity – a fine line

*Inquest into the death of Michael James Calder*

**Key Points**

- After being admitted to the Holy Spirit Northside Private Hospital for severe headaches, a healthy 33 year old male died as a result of the pain management drugs causing opiate toxicity administered during his stay.
- Pre-existing medical conditions played a role in the death, despite them not being known to treating practitioners at the time.
- The coroner identified the pain management regime administered to be improper, and also a failure to identify the deceased’s deterioration. 
  Recommendations were made on the proper procedure for clinical handovers and communication between treating staff.

**Background**

Mr Calder, a 33 year old male in good health passed away at the Holy Spirit Northside Private Hospital on 11 July 2014, after being admitted for severe occipital headaches with neck pain and stiffness. Upon admission to the Emergency Department, he was administered IV morphine and then over the course of his stay, was administered various pain management drugs including subcutaneous morphine, oxycodone, ordine, MS contin and gabapentin. It was noted that Mr Calder had been diagnosed with viral meningitis four years prior to this admission. He also had a history of obstructive sleep apnoea. This history only became known to treating practitioners after Mr Calder had died.

Mr Calder’s death was unexplained and unexpected. After a Root Cause Analysis (RCA) being conducted by the hospital, there was continued uncertainty about the precise circumstances bringing about Mr Calder’s death and an inquest was undertaken. The issues before the coroner included an assessment of the appropriateness of the care provided at the hospital.

**Findings**

The coroner found the cause of death to be opiate toxicity. Mr Calder had morphine levels in his blood within the range considered to be potentially lethal, combined with the presence of oxycodone and gabapentin. Mr Calder’s medical history, unbeknownst to Dr Brockett, the treating specialist general physician, and treating nurses at the time, contributed to his rapid deterioration. The medications administered caused a reduced level of consciousness which impaired Mr Calder’s ability to protect his airways. This resulted in aspiration pneumonia, coupled with the immediate toxic effects of opiates on the central nervous system and respiration.
In the RCA undertaken by the hospital, the failure of a night shift nursing staff to recognise and respond to early signs of clinical deterioration was identified as a factor which may have contributed to Mr Calder’s death. Mr Calder’s rapid deterioration overnight was however, confounding, with the coroner expressing it was difficult to understand how he could die from opiate toxicity while not exhibiting any overt signs of narcotisation (he appeared to be alert and coherent). Though, when considering his history of viral meningitis and sleep apnoea, it becomes more likely.

The cause of the persisting occipital headache for which Mr Calder was admitted to the hospital could not be determined.

The coroner’s findings were made while emphasising the importance of systems being in place to recognise and manage a deteriorating patient and to promote the dissemination of accurate and relevant information at clinical handovers.

It was also found that Maryann Meadowfair, a nurse, played a significant role in Mr Calder’s death and was subsequently dismissed after the incident. Ms Meadowfair, over 8, 9 and 10 July 2014, administered pain relief to Mr Calder in response to his complaints of great pain. When questioned, EEN Meadowfair admitted that she was aware of the deceased’s previous admission for viral meningitis and had a ‘query’ as to his sleep apnoea (rather than a specific knowledge).

It should be noted also that Mr Calder had in fact had surgery for his sleep apnoea at the same hospital he passed away at. Despite this, his previous medical records evidencing the surgery were not made immediately available on the ward.

Dr Brockett reflected on his part in Michael’s death and accepted his medication regime as wrong, instituting a new framework for future pain management.

Lessons Learnt

The unfortunate death of Mr Calder, at only 33 years of age, provides a warning to doctors in devising their pain management medication regime. Though this case is a unique one, whereby the deceased did not show any classic outward signs of toxicity, the coroner was concerned about the failure of any nursing staff or his treating doctor to identify Mr Calder’s deterioration.

More importantly, the issue of communication was a major source of concern for the coroner. The communication deficiencies encompassed the failure of previous medical records from the same hospital to be made available on the ward, poor clinical handover practice between nursing staff and a failure of Mr Calder’s low oxygen saturation during admission to be relayed to other staff, leading to an incorrect treatment plan and respiratory depression.

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